TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Michael S. Setliff, D.C.

Respondent Name
LM Insurance Corporation

MFDR Tracking Number
M4-16-3773-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 19, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This dispute is in regards to a designated doctor exam I was asked to perform on this injured worker. The exam I was asked to perform was for extent of injury. The fee schedule allows for $500.00 payment for this service, which I have billed and also submitted a request for reconsideration both of which were denied payment. This was a state ordered exam which was performed. I did not understand the carrier's claim that we billed improperly using the wrong coding because on our end we did bill this properly."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement was denied because the bill is lacking a required modifier."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2015	Designated Doctor Examination (99456-W6)	$500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - E483 – Modifier is required for this procedure. Resubmit service with appropriate modifier.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

The requestor is seeking reimbursement for a designated doctor examination to determine the extent of the injured employee's compensable injury, represented by procedure code 99456 with modifier "W6." The insurance carrier denied disputed services with claim adjustment reason code E483 – "Modifier is required for this procedure. Resubmit service with appropriate modifier."

28 Texas Administrative Code §134.204(i) states that a designated doctor's examination to determine the extent of an injured employee's compensable injury "shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W6.'" Subsection (k) states,

> The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports...

Review of the submitted information finds that the requestor did not include modifier "RE" as required by 28 Texas Administrative Code §134.204(k). The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	August 31, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.